AULTCARE

INDIVIDUAL & FAMILY

Health Benefit Plans for Northeast Ohio

Open Enrollment: November 1, 2024 - January 15, 2025.

You matter.

8209/24

WHAT DOES AULTCARE OFFER?

As a leader in the healthcare industry for over 39 years, AultCare continues to keep members satisfied through innovative plan designs, superior customer service, and a cost-effective high quality network.

New plans offer:

- Guaranteed coverage / no pre-existing conditions
- Prescription drug benefits
- $0 cost preventive care visits (in-network)
- $0 cost flu shots (in-network)
- No forms to complete for claims (in-network)
- No lifetime dollar maximum limits on covered services

Coverage levels to meet your needs:

- Individual
- Individual and Spouse
- Individual and Child(ren)
- Entire Family

The following services are available 24/7 at www.aultcare.com:

- Access to your healthcare coverage, member ID cards, Explanation of Benefits, coverage details, claims, & more
- Prescription Plans & Formulary
- Physician's directory with search by name, location, or specialty

You can find information about non-covered benefits, practitioner and provider availability, utilization management procedures, pharmaceutical management procedures, and privacy rights at www.aultcare.com or 330-363-6360 (TTY: 711).

AULTCARE CUSTOMER SERVICE

Our strengths are at your service:

- REAL people answering the phone when you call
- Local service: 330-363-6360 (TTY: 711)
- 24/7 Nurse hotline: 1-866-422-9603
- Email access: aultcare@aultcare.com
- In-person access at: 2600 Sixth Street S.W. Canton, Ohio 44710

AULTCARE **continues to develop innovative products & plan designs to meet the needs of families & individuals.**

AultCare's Marketplace plans are available in the highlighted counties.

AULTCARE

Helping you navigate the Marketplace

The 2025 Open Enrollment period begins November 1, 2024 and continues through January 15, 2025. A life-changing event may allow you to shop for health plans outside of the Open Enrollment period.

Life-changing events include:

- Marriage
- Birth of a child
- Moving into a new network
- Divorce
- Loss of insurance/job that provided insurance
- Aging out of parent's insurance (26 years of age)

AultCare offers many options in the following metal categories. Review our plans to see which fits your needs. Below is a quick look at the coverage:

Metal Plan	Average Health Plans Payment*
Bronze	60%
Silver	70 %
Gold	80 %

What factors affect your health plan costs?

- Age
- Family size
- Tobacco use
- Location
- Plan metal level

Dental & Vision options are available with some plans. Be sure to add those to your selections, if needed.

You've selected your plan, what does it include?

New AultCare health plans include:

- Prescription coverage
- Inpatient services
- Outpatient services
- Maternity coverage
- Newborn care services
- Pediatric services
- Emergency services
- In-network preventive care services such as screenings and physicals
- Ongoing Disease Management
- Urgent care services
- Laboratory services (blood work, screenings)
- Rehabilitation services
- Substance abuse services
- Mental health coverage
- Durable medical equipment services

The National Committee for Quality Assurance (NCQA) has awarded AultCare with NCQA Health Plan Accreditation for our Commercial PPO, Commercial HMO and Marketplace PPO products. NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.

ACCREDITED NCQA HEALTH PLAN — COMMERCIAL HMO

ACCREDITED NCQA HEALTH PLAN — COMMERCIAL PPO

ACCREDITED NCQA HEALTH PLAN — MARKETPLACE PPO

These NCQA seals represent NCQA Health Plan report card year 2024-2025.

AultCare Insurance Company Individual Marketing Brochure

Enclosed is the Schedule of Benefits for this policy. This policy contains exclusions, limitations, reduction of benefits and certain terms under which the policy may be continued in force or discontinued. For costs and complete details of coverage, call or write your insurance agent or AultCare Insurance Company.

**Source: HealthCare.gov*

Silver 7900 (CSR 94) 2025 01January
Effective Date: 01/01/2025

SILVER 7900 PREMIER SELECT CSR 94

Company Name (also specify name for ID cards if different):	INDIVIDUAL (PREMIER SELECT NETWORK): 6106 Plan -No Pediatric Dental
Plan Numbers	Shared plan. Plan number intentionally left blank.
Plan Design	PPO
Company Effective Date:	01/01/2014
What is the effective date of new plan or plan change ?:	01/01/2025

PERCENTILE TO PAY

Network Providers are paid based on AultCare's contracted rate (75th percentile). If different, please reflect in drop down.	Contracted Rate
Non Network Providers	Reference Based Pricing

Notes:

PREMIER SELECT NETWORK: NETWORK FACILITIES CONSIST OF AULTMAN, AULTMAN ALLIANCE, AND AULTMAN ORRVILLE HOSPITALS. // Federal No Surprise Act – Surprise Billing protections may apply.

All benefit limitations or maximums shall be considered on a paid basis unless specifically noted otherwise.

NEW COMPANY

Will deductible credit be given?	Yes
By report	Yes
By EOB	Yes
Other?:	N/A
Will out of pocket credit be given?	See Note
Other?:	Not unless existing AultCare plan.

MISCELLANEOUS PLAN PROVISIONS

Do we follow AultCare's UM guidelines for this Company? If No, verify with Manager or Underwriting on an increased administrative fee.	Yes
Are there any unique plan provisions?:	NON GRANDFATHERED/HRSA

Notes:

Gender Dysphoria is covered. Please refer to the Gender Reassignment Surgery Medical Policy.

RUN IN (NEW GROUPS) RUN OUT (TERMED GROUPS)

Will AultCare administer run-in?	No
Will AultCare administer run-out?	No

ANCILLARY BENEFITS

DENTAL PLAN	No
VISION PLAN	No

FLEXIBLE SPENDING ACCOUNT	No
LIMITED FLEXIBLE SPENDING ACCOUNT (HSA compatible)	No
LIFE	No
HEALTH REIMBURSEMENT ACCOUNT	No
SHORT TERM DISABILITY	No

MEDICAL BENEFITS

ABORTION

Is elective abortion covered? **No**

Standard: Medically necessary/Therapeutic is covered as allowed under applicable law, unless noted below.

Refer to Surgery for benefit level.

ACUPUNCTURE

Is acupuncture covered? No

Refer to Physical Therapy for benefit level unless otherwise noted.:

ALLERGY EXTRACT	**50%[1]**	**40%[2]**
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
ALLERGY INJECTIONS		
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
ALLERGY TESTING		
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		No
AMBULANCE		
Benefit Level	50%[1]	50%[1,7]
Which deductible applies?	Network	Network
Which out of pocket applies?	Network	Network
Should we consider billed charges when using non network provider?		No
ANESTHESIA		

Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
ANNUAL PLAN MAXIMUM		
What is the Annual Plan Maximum?	UNLIMITED	UNLIMITED
ARTIFICIAL INSEMINATION		
Is artificial insemination covered?		No
Refer to Infertility Services for benefit level.:		
IN VITRO FERTILIZATION		
Is in vitro fertilization covered?		No
Refer to Infertility Services for benefit level.:		
ASSISTANT SURGEON		
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
ATTENTION DEFICIT DISORDER/ADHD THERAPY		
Does this plan cover Attention Deficit Disorder/ADHD Therapy?		Yes
If yes, coverage will be based on services rendered.		
BIOFEEDBACK		
Office	NOT COVERED	NOT COVERED
Outpatient	NOT COVERED	NOT COVERED
Inpatient	NOT COVERED	NOT COVERED
BIRTH CONTROL/INJECTIONS/AIDS		
Does the Women's Preventive Services Act apply? If yes, all FDA approved Birth Control will be covered - see AultList for details. NOTE: Surgery-includes all related services.		Yes
Benefit level	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Does this Benefit have any limitations?		No
BREAST PROSTHESIS/BRA		
UM Guideline: Covered based on the Women's Health and Cancer Act of 1998. First External Breast Prosthesis following surgery. If there is significant weight gain or loss, replacement would be approved by UM. Otherwise, one every 24 months.:		

Plan allows 4 Post-Mastectomy Bras per calendar year, does plan design allow more?	No	
Refer to DME for Benefit Level.		
CALENDAR OR PLAN YEAR?	**Calendar Year**	
CARDIAC REHAB (Phase I, II, III)		
Inpatient (Phase I) begins approximately 2-4 days following a heart attack, or 24 hours post-heart Surgery. Patients are assisted through range of motion exercises, which gradually progress to walking or stair climbing by the time of discharge.	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient (Phase II) is an outpatient, Hospital-based program, usually of 2-3 months duration. Patients engage in a monitored program of exercise therapy, health education and individualized or group support sessions.	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Phase III is an outpatient exercise program held at various community fitness facilities. Patients engage in conditioning activities supervised by a Registered Nurse and an exercise physiologist. This is not a covered service.:		
Limitation Notes:		
Outpatient is limited to 36 visits per calendar year.		
CHEMO/RADIATION THERAPY		
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?	No	
CHIROPRACTIC SERVICES		
Musculoskeletal (includes Vertebrae)?	Yes	
Vertebrae only?	No	
Maintenance care?	No	
Office	Based on Service	Based on Service
Limitation Note:		
Specialist office visit benefit applies.		
Manipulation Therapy	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Diagnostic Services	Based on Service	Based on Service
Modality Services	Based on Service	Based on Service
Does this Benefit have any limitations?	Yes	
Accumulation Type	Calendar Year	
Manipulation Therapy		
Limitation Notes:		

Modalities are included with Physical Therapy and Occupational Therapy limitations.		
CLAIM SUBMISSION TIME restriction (in months).		**24**
COLONOSCOPY/SIGMOIDOSCOPY		
Are routine Colonoscopy services covered?		Yes
Does this benefit include sigmoidoscopy? (If No, routine will be considered under physical exam.)		Yes
Does this include all Office or Outpatient related charges?		Yes
Is this service included in the routine physical benefit? If yes, refer to Physical for benefit level.		Yes
Does this Benefit have any limitations?		No
COMMON ACCIDENT DEDUCTIBLE - If two or more family members are injured in the same accident, only one deductible will be taken for expenses related to that accident.		
Does common accident deductible apply?		No
COORDINATION OF BENEFITS		
COB: When secondary payment combined with the primary carrier's payment, will not exceed the plan's allowed amount. We will never pay more than our normal liability would have been in the absence of other coverage.		Yes
MANDATORY SPOUSAL POLICY: (if spouse has medical offered thru their employer they are required to take that coverage.) Is there a mandatory spousal policy?		No
COPAYMENTS		
Does this plan have office visit copayments?		Yes
Primary Care Physician	$10	
Specialist	$80	
Apply one copayment per physician per day for office visits?		Yes
Do copayments apply to services when no office visit charge is billed?		No
Are there other copayment amounts?		Yes
NOTE: If "Network only" is used to designate copayment application, this will include any non-network benefit which pays the same as the network benefit (i.e. emergency care or urgent care).		
Do all (medical/Rx) copayments apply to medical deductible?		No
If no, do any specific copayments apply to the medical deductible?		No
Do all (medical/Rx) copayments apply to medical out of pocket?		Yes
DEDUCTIBLES		
--- Individual Deductible	$50	$150
--- Family Deductible	$100	$300
Are deductibles based upon Calendar or Plan year?		Calendar Year
Does the plan include last quarter carryover?		No
Are deductibles amounts embedded?		Yes
Do deductible amounts accumulate from "all members" to meet the family deductible?		Yes
Do network and non-network deductibles amounts accumulate towards each other (integrated)?		No
Is there a separate deductible for a specific benefit?		No
DENTAL/PEDIATRIC (Optional)		

DENTAL/PEDIATRIC – This is optional. Confirm enrollee has chosen this as part of plan thru benefit class codes. Services are covered to age 19 unless otherwise stated. – See Dental Language for more information

Benefit level NOT COVERED NOT COVERED

• Periodic/Limited/Comprehensive /Comprehensive Periodontal Evaluations- 1 every 6 months.:

• Dental Intraoral-complete series- 1 every 60 months.

• Bitewings- single film, two films, four films, vertical (7-8 films); 1 set every 6 months.:

• Panoramic film- 1 every 60 months.

• Cephalometric Xray/Oral/Facial Photographic Images/Diagnostic Models:

• Prophylaxis- 1 every 6 months.

• Topical application of fluoride (excluding prophylaxis)- limited to 2 every 12 months.:

• Topical fluoride varnish - 2 in 12 months.

• Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months :

• Preventive resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months. :

• Space maintainer – fixed – unilateral/bilateral/removable- unilateral/bilateral - Limited to children under age 19:

• Re-cementation of space maintainer - Limited to children under age 19

Benefit level NOT COVERED NOT COVERED

• Orthodontia - Medically Necessary; services before 1/1/17 subject to a 24 month waiting period; services after 1/1/17 a waiting period does not apply.

• Palliative treatment of dental pain- minor procedure

• Amalgam 1 or more surfaces, primary or permanent

• Resin-based composite 1 or more surfaces, anterior

• Re-cement inlay and crowns

• Prefabricated stainless steel crown- primary tooth - Limited to 1 per tooth in 60 months:

• Prefabricated stainless steel crown- permanent tooth- Limited to 1 per tooth in 60 months:

• Protective Restoration/Pin Retention- per tooth, in addition to Restoration:

• Pulpal Therapy (resorbable filling)- anterior, primary tooth (excluding final restoration):

• Pulpal Therapy (resorbable filling)- posterior, primary tooth (excluding final restoration):

• Inlay/Onlay/Crown

• Root Canal

DENTAL SERVICES COVERED UNDER MEDICAL PLAN

Dental procedures covered under medical are services such as hospital charges if required to safeguard patient's health, oral surgery, (i.e. osseous surgery), removal of partial or full impactions, cysts or tumors, and accidental injury to teeth. :

Benefit levels are based on services rendered. Please indicate under NOTES if guidelines are different.:

Notes:

Dental services for accidental injury are limited to $3,000 per episode for surgical treatment and anesthesia.

DIAGNOSTIC TESTING/LABORATORY/X-RAY

office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		No

DIALYSIS

Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network

DURABLE MEDICAL EQUIPMENT

UM Guidelines require prior authorization for any item greater than $2,500.:

Benefit Level	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		No
Orthotics	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		No
Prosthetics		
Refer to DME for Benefit Level		
Does this Benefit have any limitations?		No
Are wigs covered?		Yes
Refer to DME for Benefit Level		
Does this Benefit have any limitations?		Yes

Limitation Notes:

Wigs are only covered following cancer treatment.

Are diabetic supplies covered?	Yes

Diabetic Supplies	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		See Note

Limitation Notes:

Diabetic services and admin fees provided by AllHealth are payable are 100% of the AllHealth contracted rate. // Certain Diabetic supplies are available through the Pharmacy Program with no cost share. // Gestational Diabetes Program, via LivingConnected, includes clinical coaching, real time glucose monitoring and supplies with no cost share to the member.

DIABETIC TRAINING - Refer to Training Manual

Is diabetic training covered?		Yes
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network

EDUCATION AND TRAINING - Refer to Training Manual

Is education and training covered?		Yes
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network

MEDICAL NUTRITION THERAPY - Refer to Training Manual

Is medical nutrition therapy covered?		Yes
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network

Limitation Notes:

Additional Preventive services: Preventive Services Nutritional Counseling to prevent obesity in children and to prevent cardiovascular disease in adults with cardiovascular risk factors is limited to a total of 4 visits per benefit period.

EMERGENCY SERVICES

Emergency Services -Emergent	100%	100%[7]
Copayment (Copayment will be taken on facility charge unless otherwise noted)	$450	$450
Emergency Room Physician	100%	100%[7]
Is copayment waived if admitted?		Yes
Does emergency copayment apply to all services rendered (physician and facility)?		No
Does emergency copayment apply to facility charge only?		Yes
EYE EXAM (ROUTINE)		
Are routine eye exams covered under the medical plan?		Yes
Benefit level	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Does this Benefit have any limitations?		Yes
Limitation Notes:		
ROUTINE VISION CARE (PROFESSIONALLY INDICATED REFRACTION AND DILATION) IS ONLY COVERED TO AGE 19 *** NOT COVERED FOR ADULTS* ADDITIONAL BENEFIT LEVEL: Network: 50% after Network deductible; Non-Network 40% RBP after Non-Network deductible. // Additional Benefits include: 1 set of glasses per year; 1 prescription of lenses per year (coverage includes: Single vision, or conventional bifocal, or trifocal, or lenticular lenses. Lenses may be glass, plastic, or polycarbonate with scratch resistant and/or ultraviolet protective coating.) In lieu of glasses, 1 prescription of contacts are covered, including fitting/evaluation/follow-up care.		
GENE AND CELL THERAPY		
Are Gene and Cell Therapy Services covered? If yes, benefits will be based on services rendered.		Yes
Notes:		
Gene and cell therapy is managed by Emerging Therapy Solutions.		
GENETIC COUNSELING AND TESTING		
Is genetic counseling and testing a covered service?		Yes
UM Approval Required. Coverage will be paid based on services rendered.:		
GYNECOLOGICAL EXAM (PAP TEST)		
Are routine GYN Exams covered?		Yes
Benefit Level - Office Visit	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Other Services - GYN	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Does this Benefit have any limitations?		No
Are routine PAP Tests/Smears covered?		Yes
Benefit level	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Does this Benefit have any limitations?		No
HABILITATIVE SERVICES		
Benefit level	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network

Services are mandated age 0 to age 21. This plan allows to what age?		No Limit
Speech/Language/Occupational Therapy limited to how many visits each per calendar year?		20
Therapies for Applied Behavioral Analysis are limited to how many hours per week?		20
Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans. :		
HEARING (EXAM/AID)		
Are Routine Hearing Exams covered?		No
Does this Benefit have any limitations?		No
Are Hearing Aid and/or Fittings covered?		No
Does this Benefit have any limitations?		No
HOME HEALTH CARE		
Benefit Level - UM Approval Required	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Notes: One Aultman Home Health visit within 3 days of discharge from Aultman (all facilities) or Union Hospitals is covered at 100%, no cost share, and does not count toward the Home Health maximum.		
Does this Benefit have any limitations?		Yes
Accumulation Type		Calendar Year
Visits	100	
HOSPICE CARE		
Benefit level (UM Approval Required)	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Is Bereavement Counseling covered or not covered?		Covered
Does this Benefit have any limitations?		No
IMMUNIZATIONS		
Are Routine Immunizations past well child age limit covered?		Yes
Benefit level	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Does this Benefit have any limitations?		No
INFERTILITY MEDICATIONS		
Are infertility drugs covered under prescription plan? If yes, refer to Pharmacy for details. Pharmacy Approval Required.		No
Are infertility drugs covered under medical plan? Pharmacy Approval Required.		No
Does this Benefit have any limitations?		No
INFERTILITY TESTING		
Is Infertility testing covered?		Yes
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network

Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
INFERTILITY TREATMENT		
Is treatment of infertility covered?		No
INJECTIONS (MEDICAL)		
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		No
INPATIENT HOSPITAL		
Ancillary Services (Hospital Related Charges)		
Benefit level	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
INPATIENT PHYSICIAN SERVICES		
Benefit level	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		No
INPATIENT ROOM		
Semi-Private	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Is there a separate deductible per admission for inpatient?		No
Is there a separate copayment for inpatient admissions?		No
Does this Benefit have any limitations?		No
LIFETIME MAXIMUM		
What is the Lifetime Maximum?	None	None
Is there an automatic reinstatement provision?		No
MAMMOGRAM (ROUTINE)		
Are routine mammograms covered? (This benefit is for the actual routine mammogram. The office visit, depending on how billed, will pay under physical or GYN benefit.)		Yes
Benefit level	100%	40%[2,4]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Does this Benefit have any limitations?		No
MASSOTHERAPY		

Is Massotherapy covered when rendered by an LPT, DC, or MD?	Yes
Are Massotherapists covered?	No

Refer to Physical Therapy for benefit level.:

MATERNITY

Is coverage based on services rendered?	Yes

Notes:

Gestational Diabetes Program and admin fees provided by LivingConnected are payable at 100% of the contracted rate.

ULTRASOUND (Routine Maternity)

UM guideline effective 1/1/2020 - Maternity Ultrasounds are covered as any other diagnostic service. (UM Guidelines prior to 2020: Ultrasounds on patients age 30 and over are permitted. • Routine ultrasounds for patients under 30 years of age are not covered. • Ultrasounds for medical reasons, other than routine, are eligible for all patients regardless of age.) :

Does this plan follow UM Guidelines	Yes
Does this Benefit have any limitations?	No

MATERNITY-DEPENDENT

Are maternity expenses (maternity and delivery charges for mother and baby) of a dependent child covered?	Yes

For a dependent child's newborn expenses (charges after the initial delivery) to be covered, refer to Eligibility - Dependents for details:

Notes:

Gestational Diabetes Program and admin fees provided by LivingConnected are payable at 100% of the contracted rate.

MENTAL HEALTH, ALCOHOL AND/ OR SUBSTANCE ABUSE

Is medically necessary court ordered treatment covered? If covered, UM will review to determine medical necessity.	Yes
Are mental health benefits carved out?	No
Is there an Employee Assistance Program (EAP) available?	No
Does the Mental Health Parity and Addiction Equity Act of 2008 apply to this plan? NOTE: If yes, all mental health, alcohol and/or substance abuse claims are paid based upon services rendered.	Yes

MHPA of 2008 Mental Health/Substance Abuse Inpatient Coverage will be paid the same as any other inpatient stay UNLESS NOTED BELOW. Refer to Inpatient Hospital for benefit level.

Limitation Notes:

Includes Residential Treatment Facilities.

MHPA of 2008 Mental Health/Substance Abuse Outpatient Treatment Program -In lieu of an inpatient stay (PHP or Partial Hospital Program) or Outpatient treatment (IOP or Intensive Outpatient Program) will be paid as any other outpatient service.	50%[1,3]	40%[2,3]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network

MHPA of 2008 Mental Health/Substance Abuse Psychotherapy - Office Visit (same as PCP Office Visit): Refer to Physician Office for benefit level.

Limitation Notes:

The Mental Health Parity and Addiction Equity Act of 2008: Mental Health/Addiction Inpatient coverage will be paid the same as any other Inpatient stay. Refer to Inpatient Hospital for benefit level. Includes Residential Treatment facilities.

Mental Health/Substance Abuse Psychotherapy - Office Visit will be considered same as PCP office visit.

MHPA of 2008 Mental Health/Substance Abuse Psychological Testing: Refer to Diagnostic Services for benefit level.:

OBESITY

Is treatment of obesity a covered service? If covered, benefit level of services will be based on service rendered-refer to that section for details. UM Approval Required.:

No

Are gastric restrictive procedures covered?		No
Does this Benefit have any limitations?		No

OCCUPATIONAL THERAPY (OT)

Injury or Illness related		
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		Yes
Accumulation Type		Calendar Year
Visits	40	
Are limitations combined with speech therapy?		No
Are limitations combined with physical therapy?		Yes

Limitation Notes:

Outpatient and office Physical/Occupational therapy (including chiropractic modalities) is limited to 40 visits combined per calendar year.

OFFICE VISITS

PRIMARY CARE PHYSICIAN - Illness	100%	40%[2]
Copayment	$10	
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
PRIMARY CARE PHYSICIAN - Injury	100%	40%[2]
Copayment	$10	
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
SPECIALIST - Illness	100%	40%[2]
Copayment	$80	
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
PRIMARY CARE PHYSICIAN - Injury	100%	40%[2]
Copayment	$80	
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Are OB/GYN visits paid as PCP?		No

ORGAN DONOR

UTILIZATION MANAGEMENT APPROVAL REQUIRED.

Organ Donor		Based on Service	Based on Service
COB with donor's coverage? If Yes, benefits will be coordinated with donor unless charges are included in global fee.		Yes	
Does this Benefit have any limitations?		Yes	
Accumulation Type		Per Transplant	
Dollars Maximum	$30,000		

Limitation Notes:

Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure are covered under this Plan. The Unrelated donor search Benefit is limited to $30,000 per Transplant Benefit period. Live Donor Health Services are also covered under this Plan unless donor Benefits are available to the donor from another source.

ORGAN TRANSPLANTS

UTILIZATION MANAGEMENT APPROVAL REQUIRED.

Organ transplants which are not experimental or investigational are covered.

What is the benefit level?		Based on Service	Based on Service
Does this Benefit have any limitations?		No	
Does plan have a "separate" acquisition/transportation/lodging benefit for recipient and family?		Yes	
If yes, at what benefit level:		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network
Does this Benefit have any limitations?		Yes	
Accumulation Type		Per Transplant	
Dollars Maximum	$10,000		

Limitation Notes:

Travel expenses includes transportation to and from the facility and lodging for the Patient and one companion, all charges will need to be reasonable, necessary, and itemized. The Transplant Transportation and Lodging benefit is limited to $10,000 per Transplant Benefit period.

OUT-OF-POCKET

Individual Out of Pocket		$650	$27,600
Family Out of Pocket		$1,300	$55,200
Does Medical Network out of pocket amounts include Rx?		Yes	

Limitation Notes:

This plan follows the Marketplace Managed Formulary. // Prescription medication coupon, discount, or other manufacturer assistance programs for Specialty or other qualified medications will not apply to the Deductible or Out-of-Pocket Maximum.

Are the out of pocket amounts based upon calendar or plan year?	Calendar Year
Are the out of pocket amounts embedded?	Yes
Do network and non-network out of pocket amounts accumulate towards each other (integrated)?	No
The family out of pocket is satisfied when either all members or number of family members have satisfied their individual out of pocket. Do out of pocket amounts accumulate from "all members" to meet the family out of pocket?	Yes
Is the deductible included in the out of pocket maximum?	Yes
Does the plan includes last quarter out of pocket carryover?	No

PAIN MANAGEMENT

Coverage based on service rendered.:

PHYSICAL EXAM

Are routine physical exams covered?		Yes
Benefit level - Office Visit	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Other Services (i.e. preventive screenings)	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Does this Benefit have any limitations?		See Note

Limitation Notes:

Covered Services for a routine physical include, but are not limited to, the Physician's office visit charge and related tests, x-rays, routine cancer screenings, routine mammograms, routine gynecological exam, routine pap, age and gender appropriate screening, routine prostate screening, lab work and immunizations. These Network services will be paid at 100% unless the routine physical is not defined as a Preventive Health Service.

PHYSICAL THERAPY (PT)

Injury or Illness related		
Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		Yes
Accumulation Type		Calendar Year
Visits	40	
Are limitations combined with speech therapy?		No
Are limitations combined with occupational therapy?		Yes

Limitation Notes:

Outpatient and office Physical/Occupational therapy (including chiropractic modalities) is limited to 40 visits combined per calendar year.

PODIATRY SERVICES

Office	Based on Service	Based on Service
Limitation Notes:		
		Specialist office visit benefit applies.
Diagnostic Testing	Based on Service	Based on Service
Copayment		
Surgery-Office	Based on Service	Based on Service
Surgery-Outpatient: See Outpatient Surgery		
Other Podiatry Services	Based on Service	Based on Service
Does this Benefit have any limitations?		No

PRE-ADMISSION TESTING

Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network

PRECERTIFICATION

Is precertification required for Network?	No
Is precertification required for Non Network?	Yes

If required, what is the precertification penalty?:

none

PRESCRIPTION DRUGS

The physician charges for the administration (injection/infusion) of a prescription purchased at a retail pharmacy or through mail order is covered under the medical plan.:

Medications dispensed in a physician's office are considered as other miscellaneous office services.:

Who is the drug program carrier?

PDM/Express Scripts/Optum RX - If yes see Aultshare pharmacy for details.:

Yes

Copays?:

Yes

Notes:

Retail (34-day supply) Tier 1 Zero Cost Share Preventive - $0 Copayment, Tier 2 $10 Copayment, Tier 3 $50 Copayment, Tier 4 50% Coinsurance after Network Deductible. A 60-day supply of preferred generic medication may be obtained at the retail pharmacy for $30 Copayment or 20% whichever is greater. *** Mail Order (90-day supply) Tier 1 Zero Cost Share Preventive - $0 Copayment, Tier 2 $30 or 20% whichever is greater, Tier 3 $55 or 50% whichever is greater, Tier 4 50% Coinsurance after Network Deductible, ***Specialty Meds - (30-day supply) - must be filled through AultCare contracted specialty pharmacy network. Tier 5 50% Coinsurance after Network Deductible, Tier 6 50% Coinsurance after Network Deductible.

HDHP/ Deductible applies first (Discount Card) Also complete section under medical plan:

No

Notes:

Marketplace Managed Formulary 1/1/2021.

SaveonSP/OptumRX VCS? :

No

Notes::

Generic Incentive Program effective 1/1/2024.

Outside Vendor (i.e. Caremark, Express Scripts):

No

Will secondary drug charges be processed under the medical plan?	No

Medical Plan:

No

Notes:

Copayment after your plan's medical out of pocket maximum is reached is $0.

Are any items (specialty drugs, injectable, infusions, etc.) not covered by the pharmacy plan covered under medical?	Yes
Does this Benefit have any limitations?	No

PRIVATE DUTY NURSING

Benefit Level - UM Approval Required		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network
Does this Benefit have any limitations?			Yes
Accumulation Type			Calendar Year
Visits	90		

PROSTATE/PSA SCREENINGS

Are routine Prostate/PSA screenings covered?			Yes
Benefit level		100%	40%[2]
Which deductible applies?			Non-Network
Which out of pocket applies?			Non-Network
Does this Benefit have any limitations?			No

RECONSTRUCTIVE SURGERY

UM Approval Required. Refer to Surgery section for benefit. :

REHABILITATION SERVICES

Illness or Injury related			
Inpatient		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network
Does this Benefit have any limitations?			Yes
Accumulation Type			Calendar Year
Days	60		

Limitation Notes:

Physical Rehabilitation Facilities include coverage for Day Rehab Program services subject to combined 60 day limit with inpatient services.

RESPIRATORY THERAPY

Office		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network
Outpatient		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network
Inpatient		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network

Notes:

Pulmonary Rehab claims will pend for manual review, refer to Training Manual for processing guidelines.

Limitation Notes:

PULMONARY REHABILITATION: Limited to 20 visits per calendar year; When rendered in the home, Home Care Services limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.

Includes outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

SECOND SURGICAL OPINION			
How is Second Surgical Opinion to be paid?		Based on Service	Based on Service
Is second surgical required for Network?			No
Is second surgical required for Non-Network?			No
SKILLED NURSING FACILITY			
Benefit Level - UM Approval Required		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network
Does this Benefit have any limitations?			Yes
Accumulation Type			Calendar Year
Days	90		
TOBACCO CESSATION (Medical Plan)			
Are services covered under the medical plan? If no, refer to Pharmacy plan listing.			Yes
If yes, benefit level is		100%	40%[2]
Which deductible applies?			Non-Network
Which out of pocket applies?			Non-Network
What services are covered under the medical plan?			
Hypnosis			Not Covered
Counseling			Covered
Drug Aids			See Rx
Does this Benefit have any limitations?			No
SPEECH THERAPY (ST)			
Injury or Illness related			
Office		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network
Outpatient		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network
Inpatient		50%[1]	40%[2]
Which deductible applies?		Network	Non-Network
Which out of pocket applies?		Network	Non-Network
Does this Benefit have any limitations?			Yes
Accumulation Type			Calendar Year
Visits	20		
Are limitations combined with physical therapy?			No
Are limitations combined with occupational therapy?			No
Limitation Notes:			
	Outpatient and office speech therapy is limited to 20 visits combined per calendar year.		
STERILIZATION			
Does the Women's Preventive Services Act apply? If yes, if male refer to Surgery and if female refer to Birth Control for benefit levels.:			Yes
Is reversal of sterilization covered?			Not Covered
SUBROGATION TYPE			
Pay/Pursue			Yes

SUPPLEMENTAL ACCIDENT

Does your plan include a Supplemental Accident provision?		No

SURGERY SERVICES

Office	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Outpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this plan have a Same Day Surgery Benefit?		No
Inpatient	50%[1]	40%[2]
Which deductible applies?	Network	Non-Network
Which out of pocket applies?	Network	Non-Network
Does this Benefit have any limitations?		No

TELEHEALTH/TELEMEDICINE

Telehealth refers to virtual services rendered by a provider, including behavioral health. Telemedicine refers to virtual services rendered by our preferred virtual vendor.

Is Telehealth covered?		Yes
Illness/Injury	Based on Service	Based on Service
Is Telemedicine covered?		Yes
If yes, who is the vendor?		Aultman Now
Illness/Injury	100%	
Copayment	$10	
Is Telemedicine for Dermatology covered through the vendor?		Yes
Illness/Injury	100%	
Copayment	$80	
Does Telemedicine include Mental Health/Substance Abuse Psychotherapy services? (If yes, refer to Mental Health/Substance Abuse Psychotherapy for coverage - same as PCP office visit).		Yes

TEMPOROMANDIBULAR JOINT SYNDROME

Are services for Temporomandibular Joint Syndrome covered?		Yes
Plan approval required		Yes
Are benefits based on services rendered?		Yes
Does this Benefit have any limitations?		No

URGENT CARE FACILITY

NON NETWORK PROVIDERS WILL BE PAID AT THE NETWORK LEVEL FOR EMERGENT CARE SERVICES. (RBP WILL STILL APPLY TO NON NETWORK.)

Urgent Care Facility	100%	100%[7]
Copayment	$75	$75

WELL CHILD CARE

Is well child care covered?		Yes
Are immunizations included in well child care?		Yes
Exam	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network

Other Services	100%	40%[2]
Which deductible applies?		Non-Network
Which out of pocket applies?		Non-Network
Does this Benefit have any limitations?		Yes
Age limitation (through age)		20

Limitation Notes:

Covered Services for Well Child Care include, but are not limited to, the Physician's office visit charge and related tests, lab work and immunizations. These Network services will be paid at 100% unless the Well Child Care is not defined as a Preventive Health Service.

Is there a wellness dollar maximum? No

ELIGIBILITY

ELIGIBILITY (FOR INDIVIDUAL PLANS) -Is this plan offered to individuals? Yes

Effective Date: **********

Waiting Period: None.

Pre-Existing: Not Applicable.

Open Enrollment: Yes;

Late Applicants: Not Applicable.

Termination of Coverage: Coverage will terminate at end of month.

Common Law Recognized Prior To October 1, 1991: Yes.

Dependents Include: Spouse (Effective 01/01/2015 on renewal includes same sex spouse), natural children, adopted children or placed in anticipation of being adopted, children for whom you are the legal guardian, children for whom you have legal custody, QMSCO and step children.

Dependent Children Age Limit: State and Federal mandate applies; Coverage ends on: End of the billing cycle following their birthday.

Newborns/Immediate Coverage/Verification: **********

Divorce Decree Information/COB: when required

ELIGIBILITY (FOR SMALL GROUP PLANS) Is this plan offered to small groups? No

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[1]A Calendar Year Deductible of $50 per Covered Person / $100 per Family is applied first before any Covered Services are paid to Network Providers and designated Covered Services to Non-Network Providers. The Deductible, Copayments and Coinsurance are subject to an Out-of-Pocket Maximum of $650 per Covered Person / $1,300 per Family. Once you have met this maximum, the Plan begins to pay medical and prescription Covered Services at 100%.

[2]A Calendar Year Deductible of $150 per Covered Person / $300 per Family is applied first before Covered Services are paid to Non-Network Providers. Payments to Non-Network Providers for Covered Services are based on Reference Based Pricing criteria (RBP). Deductible and Coinsurance are subject to an Out-of-Pocket Maximum of $27,600 per Covered Person / $55,200 per Family. Once you have met this maximum, the Plan begins to pay medical Covered Services at 100% RBP.

[3]Covered Services are paid in accordance with Mental Health Parity and Addiction Equity Act of 2008, which prohibits discrimination in the coverage for diagnosis, care, and treatment of Mental Health and/or Substance Abuse.

[4]Your Copayment and/or Coinsurance plus the Plan payment to the provider and/or facility constitutes full payment for a screening mammogram.

[5]Preventive Health Services are the recommended preventive services required to be covered without cost sharing under federal law.

[6]DEDUCTIBLES AND OUT-OF-POCKETS ARE EMBEDDED. Each member of a family is looked upon as an individual in regard to the Deductible and Out-of-Pocket. Once a member reaches the individual Deductible, Coinsurance will apply for that member. Once a member reaches the individual Out-of-Pocket, no Coinsurance will apply for that member.

[7]Payments to Non-Network Providers for Covered Services are based on Reference Based Pricing criteria (RBP). Charges for Non-Network Provider Covered Services that exceed the RBP amount may be Your responsibility. Federal No Surprise Act – Surprise Billing protections may apply.

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